CAMPFIRE MINISTRIES

CAMPER MEDICAL INFORMATION FORM 2012

All information given on this form is confidential.

Medical form must be completed before child's registration accepted.

Last Name: ____ First Name: ____

Date of Birth: D__________M__________Y__________ Age: __________ (as of Camp start date) Male ☐ Female ☐

Parent(s)/guardian(s) name:____ Home phone: (______) ___________________

Address: ____

Mom's work/cell phone: (______) ___________________ Dad's work/cell phone: (______) ___________________________________

Emergency alternate contact name: ____ Relationship: ___________________

Emergency Phone: (______) __________________________ Camper Care Card Number: _____________________________________

My child has previously been stung by a bee No ☐ Yes ☐ Describe reaction: ______________________________________

My child may receive Tylenol/Advil at camp No ☐ Yes ☐

My child may receive Benydryl at camp No ☐ Yes ☐

Does your child have any allergies / food allergies? No ☐ Yes ☐ If yes, please give detail: ________________________________

____

Explain reaction and indicate medication used. (medication should be brought with you) ______________________________________

____

Does participant carry an Epipen? No ☐ Yes ☐
Does your child suffer from asthma? No ☐ Yes ☐ mild ☐ medium ☐ severe ☐
Please detail: ____

Will your child be taking prescription medication during his/her time at camp? No ☐ Yes ☐
If yes, please specify the name(s) of the medication(s) and the conditions(s) being treated: *(medication should be in the **original bottle** and dispensing information written out* ____

____

Are your child's immunizations up to date? No ☐ Yes ☐ Never immunized ☐

If no, what is needed? ____

Date of last tetanus immunization __________ / __________
month year

Has your child been treated for any serious illness such as epilepsy, heart disease, diabetes, etc.? No ☐ Yes ☐ If yes, please give details: ____

Has your child ever undergone any operations or sustained any serious injuries? No ☐ Yes ☐
If yes, please provide details: ____

Does your child have any limitations which would affect his/her camp experience? No ☐ Yes ☐ Please detail explaining how you deal with it and how you would like us to deal with it: ____

____

We will always do everything possible to contact parents or guardians in case of accident or illness. It may be necessary to get immediate medical attention for your child and it may not be possible to contact you as parents prior to doing so. Your signature on the following 'permission clause', will allow us to get immediate medical help should it be necessary.

I verify that the above medical information on my child, _____________________ , is complete and accurate. I also understand that reasonable measures will be taken to safeguard the heath and safety of all participants and that I will be notified as soon as possible in case of any emergency affecting my child. In the event that I cannot be reached in an emergency, I hereby authorize the calling of a physician to provide whatever emergency medical or surgical treatment is necessary.

Parent/Guardian Name: ____
(Please Print Name)

Signed: ____ Date: ______________________________
Parent or Guardian